Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: WESTLAKE ANESTHESIA GROUP P.O. BOX 154456 LUFKIN, TX 75915	MFDR Tracking #: M4-09-7859-01
Respondent Name and Box #: STATE OFFICE OF RISK MANAGEMENT Rep Box # 45	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Pre-Auth # 650805 did not expire. Attached email & documentation from Evelyn Shead at Forte proves this. Surgeon's ofc. Rqst'd new pre-auth in Aug. '08 but was denied because #650805 was still in effect. Evelyn provided her # 800-580-2273 if clarification is needed. Please see attached copy of appeal. We request immediate payment."

Principal Documentation:

1. DWC 60 package
2. Total amount sought - $429.51
3. CMS 1500
4. EOB's

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: The Respondent did not submit a response to the request for medical dispute resolution.

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
8/21/08	01400-QZ (See Calculations Below)	198, W4	1-6	429.51
Total /Due:				$429.51

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.203, titled ***Medical Fee Guideline for Professional Services*** effective for professional medical services provided on or after March 1, 2008, set out the reimbursement guidelines.

1. These services were denied or reduced payment by the Respondent with reason codes:
   - "198-Payment adjusted for exceeded precert/preauth; and
   - W4-No additional payment allowed after review."
2. Per Rule 134.600 (p) Non-emergency health care requiring preauthorization includes: (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section." Based upon the submitted Forte report dated 4/4/08 and notation from Evelyn Shead, preauthorization approval was granted for outpatient right knee lateral meniscectomy. Ms. Shead clarified in her hand written note on the report that the preauthorization approval had no expiration date. Therefore, the insurance carrier's denial of "198" is not supported.
3. Based upon the submitted Anesthesia Record the claimant underwent right knee arthroscopy. The Anesthesia Record indicates that the anesthesiology started at 12:30 and ended at 13:32 for a total of 62 minutes.
4. The Requestor billed 01400-QZ for "Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified." The QZ modifier designates that the anesthesia was administered by CRNA and was not medically directed. Per Rule 134.203, CPT code 01400-QZ has a base unit of 4.
5. Per Rule 134.203(c)(1), the DWC conversion factor for professional services provided in a facility or an ASC by a physician is $66.32.
6. Per 28 Texas Administrative Code Section 134.203(b), the MAR for CPT code 01400-QZ is:
   - Time units = 62 divided by 15 minute increment = 4.13units
   - Base units = 4 units
   - 4.13 units + 4 units = 8.13 units
   - 8.13 units x $66.32(conversion factor) = $539.18
   - $539.18 – $0.00 amount paid by insurance carrier = $539.18

The Requestor is seeking a lesser amount of $429.51, this amount is recommended for reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1, 134.203
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $429.51 plus applicable accrued interest per Division Rule 134.130.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	August 5, 2009 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.